SECTION VIII - COMPLETION OF FORMS

VIII. COMPLETION OF FORMS

A. General

The Uniform Billing Statement (UB-82) is to be used for billing Hospice services rendered to eligible KMAP recipients. A copy of this form may be found in Appendix V of this manual.

A separate billing form is to be used for each patient.

UB-82 billing forms may be obtained from the Kentucky Hospital Association.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered and the election of hospice benefits is in effect. You cannot be paid for services rendered to an ineligible person.

The original of the invoice set should be mailed to:

EDS
P.O. Box 2045
Frankfort, Kentucky 40602

B. Completion of UB-82 MEDICAID ONLY

Following are instructions in form locator order for billing Medicaid services on the UB-82 billing statement (completion of UB-82 for Medicare/Medicaid copayment is found in Section VIII C of this manual). Only instructions for form locators required for EDS processing or KMAP information are included. Instructions for form locators not used by EDS/KMAP processing may be found in the UB-82 Training Manual. The UB-82 Training Manual may be obtained from the Kentucky Hospital Association.

SECTION VIII - COMPLETION OF FORMS

FORM
LOCATOR

1 PROVIDER NAME AND ADDRESS

Enter the complete name and address of the institution.

3 PATIENT CONTROL NUMBER

Enter the patient control number. The first 7 digits will appear on the Remittance Advice.

4 TYPE OF BILL

Enter the applicable 3 digit code that describes type of bill.

1st Digit (Type Facility): 8 = Hospice

2nd Digit (Bill Class):
1 Hospice (Non Hospital Based)
2 Hospice (Hospital Based)

3rd Digit (Frequency):
1 = Admit through discharge claim
2 = Initial billing
3 = Interim billing
4 = Final billing

8 MEDICAID PROVIDER NUMBER

Enter the Hospice Agency's 8 digit Kentucky Medicaid Provider number.

10 PATIENT NAME

Enter the name of the recipient in last name/first name sequence as shown on his/her current Medical Assistance Identification (MAID) card.

15 DATE OF ADMISSION

Enter the date on which the recipient was admitted to the hospice in month, day, year sequence and in numeric format (e.g., 01/03/86).

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR

21 PATIENT STATUS CODE

Enter the applicable 2 digit patient status code as of the through date of the billing period.

Code Structure

01 - Discharge (left care of this hospice)
30 - Still patient of this hospice
40 - Died at home
41 - Died in a medical facility, such as a hospital, SNF, ICF, or Free Standing Hospice
42 - Place of death unknown

22 STATEMENT COVERS PERIOD

From - Enter the beginning date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Through - Enter the last date of the billing period covered by this invoice in month, day, year sequence and in numeric format.

Do not show days before patient's Medicaid election period began.

28 OCCURRENCE CODE

Enter the 2 digit code that indicates whether the illness was employment or accident related.

Code Structure UB82 Manual

01 Auto Accident
02 Auto Accident/No Fault Insurance Involved
03 Accident/Last Liability
04 Employment Related Accident or Illness
05 Other Accident

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR

50 DESCRIPTION

Enter a from and through date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. PLEASE ENTER SERVICE DATES WITHIN ONE MONTH ONLY ON EACH LINE except in the case of respite care. The entire inpatient respite care stay MUST be entered on ONE line. NOTE: Please complete no more than ten lines per billing statement.

51 REVENUE CODE

Enter the 3 digit revenue code for the service being billed (A LIST OF THE REVENUE CODES ACCEPTED BY KMAP CAN BE FOUND ON PAGES 7.1 AND 7.2 OF THIS MANUAL. Also, see special instructions for billing certain revenue codes on page 8.6 of the manual). Revenue code 001 (Total Charges) must be the last revenue code listed.

52 UNITS

Enter the number of units for each service billed. Units are measured in days for code 653, 182, 183, 184, 185, 654, 651, 655, and 656, in hours for code 652, and in number of prescription drugs for 250. Units for Medicare co-payment are measured in days for 658 and in number of prescriptions for 659.

53 TOTAL CHARGES

Enter the total charges for each revenue code on the same line in column 53. The last revenue code entered in column 51 (001) represents the total of all charges billed, and that total should be the last entry in column 53.

57 PAYER

Enter the name of each payer (e.g. Medicare, Private Insurance, etc.) from which the provider might expect payment.

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR

63 PRIOR PAYMENTS

Enter the total amount (if any) received from private insurance (the amount should be listed on the corresponding line with the payer in #57). NEITHER Medicare payment amount, Medicaid payment amount, nor the recipient continuing income amount is to be entered.

65 INSURED'S NAME - REQUIRED ENTRY

Enter the name of the recipient in last name/first name sequence as shown on his/her current MAID card.

68 MEDICAL ASSISTANCE ID NUMBER

Enter the recipient's 10 digit identification number EXACTLY as shown on his/her current MAID card.

77 PRIMARY DIAGNOSIS CODE

Enter the ICD-9 diagnosis code for which the patient is receiving treatment.

78 THRU 81 OTHER DIAGNOSIS CODES

Enter other ICD-9 diagnosis codes (if any) for which the patient is receiving treatment.

92 ATTENDING PHYSICIAN ID

Enter the 5 digit license number of the attending physician.

SECTION VIII - COMPLETION OF FORMS

FORM LOCATOR

95 PROVIDER CERTIFICATION - Required

Enter the actual signature (not a facsimile) of the invoicing provider or the provider's duly appointed representative. STAMPED SIGNATURES ARE NOT ACCEPTED.

96 INVOICE DATE

Enter the date in month, day, year sequence and in numeric format on which this invoice was signed and submitted to EDS for processing.

SPECIAL INSTRUCTIONS FOR SPECIFIC REVENUE CODES

653 Room and Board SNF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 653 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

654 Room and Board ICF - Charges for room and board must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 654 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

182 ICF Bed Reservation Days Home - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 182 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

183 SNF Bed Reservation Days Home - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 183 must be billed with either 651 (Routine Home Care) or 652 (Continuous Nursing Care).

184 ICF Bed Reservation Days Hospital - Charges for ICF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 184 must be billed with 656 (General Inpatient Care).

185 SNF Bed Reservation Days Hospital - Charges for SNF bed reservation days must be billed on the same UB-82 as other daily hospice procedures for those dates (except for patients with both Medicare and Medicaid). 185 must be billed with 656 (General Inpatient Care).

655 Inpatient Respite Care - The entire inpatient respite care MUST be entered on one line.

NOTE: Claims with services dates more than twelve (12) months old can be considered for processing ONLY with appropriate documentation such as one or more of the following: Remittance statements no more than 12 months of age which verify timely filing, backdated MAID cards (the words "backdated card" should be written on the claim form and on the copy of the backdated MAID card), Social Security documents, correspondence describing extenuating circumstances, Return to Provider Letters, Medicare EOMB's etc. Without such documentation, claims over 12 months old will be denied.

C. Completion of UB-82 for Medicare Co-Payment

Following are instructions for billing the Medicare co-payment on the UB-82 billing statement. All form locators should be completed as outlined in Section VIII B of this manual with the following exceptions.

FORM LOCATOR

50 DESCRIPTION

Enter a from and to date (within this billing period) in numeric format and in month, day and year sequence for each revenue code shown on the same line in Column 51. The line item dates of service for the prescription co-payment must reflect the from and to days covered by the prescription.

SECTION VIII - COMPLETION OF FORMS

51 REVENUE CODE

Enter the 3 digit revenue code for the service being billed.

1. Respite Care Co-Payment
   a. Revenue Code: 658
   b. Unit of Service: 1 day (24 hours)

2. Hospice Drug Co-Payment
   a. Revenue Code: 659
   b. Unit of Service: 1 prescription = 1 unit

52 UNITS

Enter the number of units for each service billed. Units are measured in days for code 658 and in number of prescription for 659. Since Medicare does not allow payment for more than five (5) consecutive days of respite care, DO NOT bill for more than five (5) units for 658. Note: In the case of co-payment for drugs, the number of units will not always equal the number of days covered in the date span for the service.

A copy of the applicable Explanation of Medicare Benefits (EOMB) and a drug invoice (when applicable) must be attached to the UB-82. It is not necessary to attach a copy of the EOMB if only charges for room and board are being billed.

All other pertinent criteria for hospice coverage must be met.

NOTE: For patients with both Medicare and Medicaid, when billing for service dates which include charges for co-payments (drug and/or respite) and room and board or board reservation days all charges should be billed on the same UB-82. If no co-payment is being billed, charges for room and board and/or bed reservation days may be billed alone.

SECTION VIII - COMPLETION OF FORMS

D. Completion of Election of Medicaid Hospice Benefit Form (MAP-374)

An individual who meets the eligibility requirements for hospice care and elects to receive that care, must file an Election of Medicaid Hospice Benefits Form (MAP-374) with the particular hospice agency who will be providing the care.

The name of the individual, the MAID number, the name and provider number of the hospice agency and the effective date that hospice care begins must be entered in the appropriate spaces on the MAP-374, as well as the name of the agency who will be providing outpatient medication.

The effective date for the election period may begin with the first day of hospice care or any subsequent day of hospice care. The effective date may not be prior to the date that the election is made.

The election to receive hospice care will be considered to continue as long as the individual remains in the care of the hospice and does not revoke the election of hospice benefits. The MAP-374 will remain in effect for the duration of hospice care.

The section of the MAP-374 regarding Medicare eligibility must be completed appropriately and if Medicare eligible, the dates of Medicare eligibility must be entered. NOTE: If an individual is not eligible for Medicare benefits at the time the Medicaid hospice benefit begins but begins his/her Medicare benefits during the Medicaid benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) to the Department for Medicaid Services and the local Department for Social Insurance Office indicating the date that Medicare benefits became effective Failure to submit this information will result in incorrect payment of claims.

The section of the MAP-374 pertaining to long term care facility residents must be completed if the patient is a resident in a long term care facility at the time he/she elects the Medicaid hospice benefit. The name of the facility and the type of facility (skilled nursing or intermediate care) must be entered. If a patient enters a long term care facility during the Medicaid hospice benefit period, the hospice agency should send a Hospice Patient Status Change Form (MAP-403) to the Department for Medicaid Services and to the local

SECTION VIII - COMPLETION OF FORMS

Department for Social Insurance Office indicating the name and type of the facility in the appropriate space and the date on which the patient was admitted to the facility. Failure to submit this information could result in the incorrect determination of the patient's eligibility.

The MAP-374 must be signed and dated by the individual (or authorized representative) and a witness.

If an individual revokes the election of hospice benefits and later elects to receive hospice benefits again, the second certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the second election period will begin. Requirements for the second election period are the same as those for the initial election period. If an individual revokes the election of hospice benefits during the second election period and later elects to receive hospice benefits again, the third certification section of the MAP-374 must be completed with the signature of the individual (or authorized representative) and a witness, as well as the effective date that the third election period begins. Requirements for the third election period are the same as those for the initial and second election periods.

The second and third certification sections of the MAP-374 need not be completed if the previous benefit has not been revoked.

A copy of the MAP-374 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the election period. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-374 may be found in the Appendix Section of this manual, Appendix VI.

SECTION VIII - COMPLETION OF FORMS

E. Completion of Revocation of Medicaid Hospice Benefit Form (MAP-375)

If an individual chooses to revoke his/her Medicaid hospice benefits, he/she must file a Revocation of Medicaid Hospice Benefits Form (MAP-375) with the particular hospice agency who has been providing the hospice care.

The name of the individual, the MAID number, and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-375, as well as the effective date that the revocation begins and the individual resumes his/her regular Medicaid coverage. The effective date of the revocation may not be prior to the date that the revocation is made.

The MAP-375 must be signed and dated by the individual (or authorized representative) as well as a witness. Additionally, the hospice agency staff should complete the Rationale of Revocation section of the MAP-375.

A copy of the MAP-375 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the revocation. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-375 may be found in the Appendix Section of this manual, Appendix VII.

SECTION VIII - COMPLETION OF FORMS

F. Completion of Change of Hospice Providers Form (MAP-376)

If an individual chooses to change from one hospice agency to another for hospice care, he/she must file a Change of Hospice Providers Form (MAP-376) with both the hospice agency which has been providing care and the hospice agency which will begin providing care.

The name of the individual, the MAID number, the name and provider number of both hospice agencies and the effective date that the change of providers begins must be entered in the appropriate spaces on the MAP-376. (NOTE: A change in hospice providers is NOT a revocation of hospice benefits.)

The MAP-376 must be signed and dated by the individual (or authorized representative) and a witness.

A copy of the MAP-376 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by each hospice agency.

A copy of the original MAP-374 should be sent to the new hospice agency along with the Change of Hospice Providers Form (MAP-376).

Failure to complete forms correctly may result in delays in payment.

An example of the Change of Hospice Providers Form (MAP-376) may be found in the Appendix Section of this manual, Appendix VIII.

SECTION VIII - COMPLETION OF FORMS

G. Completion of Termination of Medicaid Hospice Benefits Form (MAP-378)

If hospice benefits for an individual are terminated for any reason, a Termination of Medicaid Hospice Benefits Form (MAP-378) must be filed by the hospice agency which has been providing hospice care.

The name of the individual, the MAID number, the effective date of the termination and the name and provider number of the hospice agency must be entered in the appropriate spaces on the MAP-378.

The block which indicates the reason for termination must be checked. If patient is deceased, the date of death must be entered. If "Other" is checked an explanation of the reason for termination must be included.

This form may also be used if a patient becomes inactive. The date the patient became inactive must be entered, and the block "Condition Improved. Patient in Long Term Inactive Status" must be checked.

(NOTE: Termination of hospice benefits is NOT a revocation of benefits.)

The MAP-378 must be signed and dated by the hospice medical director.

A copy of the MAP-378 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the termination. A copy must also be retained by the hospice agency.

An example of the MAP-378 may be found in the Appendix Section of this manual, Appendix X.

SECTION VIII - COMPLETION OF FORMS

H. Completion of Representative Statement For Election of Hospice Benefits (MAP-379)

If an individual is unable, due to physical and/or mental incapacity, to act on his/her own behalf, a legal representative may be appointed. The legal representative may sign any or all hospice forms on behalf of the individual. The name of the representative and the name of the individual and the MAID number must be entered in the appropriate spaces on the MAP-379.

The MAP-379 must be signed and dated by the legal representative and a witness.

The MAP-379 need only be completed once, at the time the representative begins acting on behalf of the individual; a copy of the completed MAP-379 must, however, accompany all other forms which the legal representative has signed on behalf of the individual.

A copy of the MAP-379 MUST be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the date when the representative begins acting on behalf of the individual. A copy must also be retained by the hospice agency.

Failure to complete forms correctly may result in delays in payment.

An example of the MAP-379 may be found in the Appendix Section of this manual, Appendix XI.

I. Completion of the Other Hospitalization Statement (MAP-383)

If a hospice recipient is hospitalized for any condition not related to the terminal illness, an Other Hospitalization Statement (MAP-383) must be completed. The name of the hospital to which the recipient is being admitted, the name and MAID number of the recipient and the actual date of the hospital admission should be entered in the appropriate spaces. The Diagnosis and the ICD 9 CM code for this hospitalization must be entered. The Diagnosis and the ICD 9 CM

code for the patient's terminal illness must be entered. The appropriate block regarding previous hospitalizations must be checked and the dates, diagnoses and ICD 9 CM codes for previous admissions must be entered when applicable. The form must be signed and dated by the medical director of the hospice. The form should be sent to the KMAP for review along with documentation which includes the terminal diagnosis, the patient's present condition and verification that the reason for this hospitalization is in NO way related to the terminal illness. After review by the KMAP, the form will be returned to the hospice agency marked "Approved by the KMAP" or "Denied by the KMAP" and signed by a KMAP representative. If approved, one copy should be sent to the admitting hospital and one copy should be retained by the hospice agency. Hospice services may not be billed during the period of hospitalization. If denied, the hospice agency must bill for the service using the revenue code for General Inpatient Care.

An example of the Other Hospitalization Statement (MAP-383) may be found in Appendix XVII of this manual.

J. Completion of Hospice Drug Form (MAP-384)

If a hospice recipient requires drugs which are not related to his/her terminal illness, a Hospice Drug Form (MAP-384) must be completed and submitted to the KMAP with the Election of Benefits Form (MAP-374). Instructions for completion of the form are as follows:

BLOCK
NO.

1 RECIPIENT LAST NAME

Enter the last name of the recipient

2 FIRST NAME

Enter the first name of the recipient

3 MEDICAL ASSISTANCE I.D. NUMBER

Enter the recipient's MAID Number exactly as it appears on his/her current MAID card.

4 DATE MEDICAID HOSPICE COVERAGE BEGAN

Enter the actual date Medicaid hospice coverage for this recipient began. The date must agree with the effective date of the Election of Benefits Form (MAP-374).

5 FIRST DIAGNOSIS (Not Related to the Terminal Illness)

Enter the diagnosis for the condition which requires the prescriptions; enter the ICD-9-CM code for the diagnosis.

SECOND DIAGNOSIS (Not Related to the Terminal Illness)

Enter the second diagnosis (if any) for the condition which requires the prescription; enter the ICD-9-CM code for the diagnosis.

6. TOTAL NUMBER OF PRESCRIPTIONS NOT RELATED TO TERMINAL ILLNESS

Enter the total number of prescriptions not related to the terminal illness.

7 DRUG NAME

Enter the name and strength (10 mg. 100 mg.) of the drug

8 NDC

Enter the NDC for the drug

9 UNITS

Enter the number of units required

10 PRICE PER UNIT

Enter the actual price per unit

SECTION VIII - COMPLETION OF FORMS

11 TOTAL CHARGE

Enter the total charge for this prescription

12 MEDICAID MAXIMUM ALLOWABLE

Leave Blank

13 TOTAL UNITS THIS INVOICE

Enter the total number of prescriptions requested on this invoice

14 TOTAL CHARGE THIS INVOICE

Enter the total charge for all prescriptions requested on this invoice

15 TERMINAL DIAGNOSIS

Enter the terminal diagnosis of the patient and the ICD 9 CM code for that diagnosis.

16 PREVIOUSLY REQUIRED PRESCRIPTIONS

Enter whether the patient required these prescriptions prior to the diagnosis of the terminal illness.

17 PRESCRIPTIONS RESULTING FROM HOSPITALIZATION

Enter whether the prescriptions are the result of a hospitalization not related to the terminal illness.

18 DATES OF HOSPITALIZATION

If "yes" is checked in block 17, enter the dates of that hospitalization.

19 NAME OF HOSPITAL

If "yes" is checked in block 17, enter the name of the hospital.

SECTION VIII - COMPLETION OF FORMS

20 PRESCRIBING PHYSICIAN

Enter the name of the physician prescribing these drugs.

21 PROVIDER CERTIFICATION AND SIGNATURE

The actual signature of the provider (not a facsimile) or the provider's authorized agent is required

22 PROVIDER NAME AND ADDRESS

Enter the complete name and address of the hospice agency

23 PROVIDER NUMBER

Enter the 8 digit Medicaid provider number of the hospice agency. The number must begin with "44."

24 INVOICE DATE

Enter the date on which this invoice was signed and submitted to the KMAP.

25 INVOICE NUMBER

No entry required

Both copies of the MAP-384 should be attached to the Election of Benefits Form (MAP-374). Documentation must also be attached which verifies that the need for these prescriptions/items is in NO way related to the patient's terminal illness. One copy will be returned to the provider by the KMAP with the allowable maximum Medicaid payment entered in Block 12 for each prescription. If payment is not allowed, "NA" will be entered in Block 12.

Only one MAP-384 need be submitted unless the hospice benefit is revoked or unless there is a change in the prescriptions required. The initial MAP-384 should be submitted with the recipient's Election of Benefit Form (MAP-374). If the hospice benefit is revoked and then reinstated, a new MAP-384 should be sent with the second or third certification period. If there is a change in the prescriptions required, an MAP-384 only should be submitted. The hospice agency should retain a copy of the invoice.

The MAP-384 should also be used when requesting prior approval for additional payment for nutritional supplements when they are required for the total nutrition of the patient. The form should be completed as for regular prescriptions with the name of the nutritional supplement entered in block 7 and the NDC number entered in block 8. Documentation from the attending physician which verifies that the nutritional supplements are required for the patient's total nutrition must be attached to the MAP-384.

An example of the MAP-384 may be found in Appendix XVIII of this manual.

K. Completion of Other Services Statement (MAP-397)

For those services which are usually covered under the hospice benefit but are being billed separately because they have been determined to be totally unrelated to the terminal illness of the patient, an Other Services Statement (MAP-397) must be completed in order to obtain approval from the KMAP. Instructions for completion of the form are as follows:

1. The name of the agency providing the service, the name and MAID number of the recipient and the date of service must be entered in the appropriate spaces.

2. The diagnosis of the condition requiring this service and the ICD 9 CM code for that diagnosis must be entered.

3. The diagnosis and ICD 9 CM code of the patient's terminal illness must be entered.

4. Items of durable medical equipment being billed separately must be specifically identified.

5. A description of hospital outpatient services and the reason for the services must be entered.

6. The form must be signed and dated by the medical director of the hospice agency.

7. Documentation which verifies that the services are totally unrelated to the terminal illness of the patient must be attached to the form.

SECTION VIII - COMPLETION OF FORMS

8. All copies of the form should be submitted to the Department for Medicaid Services, Division of Policy and Provider Services. Two copies of the form will be returned to the provider signed by a KMAP representative indicating whether separate payment for the services has been approved or denied.

9. If approved, one copy of the form should be sent to the provider who will bill for the service. The other copy should be retained by the hospice agency.

An example of the Other Services Statement (MAP-397) may be found in Appendix XIX of this manual.

SECTION VIII - COMPLETION OF FORMS

L. Completion of Hospice Patient Status Change Form (MAP-403)

This form should be used any time a patient's status changes in any way after the Election of Medicaid Benefits Form (MAP-374) is filed.

Enter the patient's name and MAID number.

Enter the name and provider number of the hospice agency.

Enter the original date of election of Medicaid hospice benefits.

Enter the effective date of this change.

Check the block which appropriately describes this change and all information pertaining to the change.

The form must be signed by the patient or his/her authorized representative and a Hospice Agency Representative.

A copy of the MAP-403 must be sent to the local DSI office and to the Department for Medicaid Services, Division of Policy and Provider Services within two working days of the effective date of the change. A copy must also be retained by the hospice agency.

Failure to complete the form correctly may result in delays in payment.

An example of the MAP-403 may be found in the Appendix Section of this manual, Appendix IX.

SECTION IX - REMITTANCE STATEMENT

IX. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the KMAP with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the KMAP with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION IX - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix XII-P1. This section lists all of those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT
FOR HOSPICE SERVICES

ITEM	
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS.
CLAIM SVC DATE	The earliest and latest dates of service as shown on the claim form
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form
CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid, (examples: rejected line item, reduction in billed amount to allowed charge)
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid program for services on the claim

SECTION IX - REMITTANCE STATEMENT

CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim
EOB	For explanation of benefit code, see back page of Remittance Statement
LINE NO.	The number of the line on the claim being printed
PS	Place of service code depicting the location of the rendered service
REV CODE	The revenue code in the line item
QTY	The number of procedures/supply for that line item charge
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item
EOB	Explanation of benefit code which identifies the payment process used to pay the line item.

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix XII-P2

All items printed have been previously defined in the descriptions of the paid claims section of the Remittance Statement.

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix XII-P3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim only appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix XII-P4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/DENIED — the total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity

AMOUNT PAID — the total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity

WITHHELD AMOUNT	the dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	the dollar amount that appears on the check
CREDIT AMOUNT	the dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount)
NET 1099 AMOUNT	the total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix XII-P5).

SECTION X - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Cash/Finance Unit

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on an R/A within a reasonable amount of time

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Photocopy of the claim in question 3. Photocopy of the applicable portion of the R/A in question
Refund	1. Refund Check 2. Photocopy of the applicable portion of the R/A in question 3. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

When to Call?

- When claim is not showing on paid, pending or denied sections of the R/A within 6 weeks
- When the status of claims are needed and they do not exceed five in number

Where to Call?

- Toll-free number 1-800-333-2188 (within Kentucky)
- Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare/Medicaid Crossover Claims	-	12 months from date of service
		NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.
Third-Party Liability Claims	-	12 months from date of service
		NOTE: If the other insurance company has not responded within 120 days of date of service, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.
Adjustments	-	12 months from date the paid claim appeared on the R/A

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-333-2188 or 1-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may NOT be used in lieu of KMAP claim forms, Adjustment forms, or any other document required by KMAP.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

SECTION X - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number. If you are a KMAP certified clinic, enter your 8 digit clinic number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid Recipient's Name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medical Assistance ID number.
5	Enter the Billed Amount of the claim on which you are inquiring.
6	Enter the Claim Service Date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE R/A MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the R/A (last name first).
3	Enter the complete recipient identification number as it appears on the R/A. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

Field Number	Description
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the R/A.
9	Enter the R/A date which is found on the top left corner of the remittance. Please do not enter the date the payment was received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Communications Unit by mail:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up postnatal visits within 4-6 weeks of the delivery date.

DENTAL SERVICES

Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.

DURABLE MEDICAL EQUIPMENT

Certain medically necessary items of durable medical equipment, orthotic and prosthetic devices may be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

FAMILY PLANNING SERVICES

Comprehensive family planning services are available to all eligible Title XIX recipients of childbearing age and those minors who can be considered sexually active. These services are offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services are also available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, are available through the Family Planning Services element of the KMAP. Follow-up visits and emergency treatments are also provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, are paid for by the program for eligible recipients, to the age of 21. Follow-up visits, as well as check-up visits, are covered through the hearing services element. Certain hearing aid repairs are also paid through the program.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy and aide services are covered when necessary to help the patient remain at home. Medical social worker services are covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services is not limited by age.

HOSPITAL SERVICES

INPATIENT SERVICES

KMAP benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions must be preauthorized by a Peer Review Organization. Certain surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures are outside the scope of program benefits unless medically necessary or indicated. Reimbursement is limited to a maximum of fourteen (14) days per admission.

OUTPATIENT SERVICES

Benefits of this program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician; clinic visits, selected biological and blood constituents, emergency room services in emergency situations as determined by a physician; and services of hospital-based emergency room physicians.

There are no limitations on the number of hospital outpatient visits or services available to program recipients.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medical Assistance Program (KMAP) participating independent laboratories includes procedures for which the laboratory is certified under Medicare.

LONG TERM CARE FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES

The KMAP can make payment to skilled nursing facilities for:

A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis.*

B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.

-Coinsurance from the 21st through the 100th day of this Medicare benefit period.
-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required.*

*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).

INTERMEDIATE CARE FACILITY SERVICES

The KMAP can make payment to intermediate care facilities for:

A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision.*

B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources.*

*Need for the intermediate level of care and the ICF/MR/DD level of care must be certified by a PRO.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

MENTAL HOSPITAL SERVICES

Inpatient psychiatric services are provided to Medicaid recipients under the age of 21 and age 65 or older in a psychiatric hospital. There is no limit on length of stay; however, the need for inpatient psychiatric hospital services must be verified through the utilization control mechanism.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. Kentucky Medical Assistance Program reimburses private practicing psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist are covered by the KMAP.

NURSE MIDWIFE SERVICES

Medicaid coverage is available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two follow-up post partum visits within 4 to 6 weeks of the delivery date.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Drug List when required in the treatment of chronic and acute illnesses are covered by the KMAP. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and physicians upon request and routinely sent to participating pharmacies and long-term care facilities. The Drug List is distributed quarterly with monthly updates.

In addition, certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization are covered for payment through the Drug Preauthorization Program.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms must be completed prior to coverage of these procedures.

Non-covered services include:

Injections, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

One comprehensive office visit per twelve (12) month period, per patient, per physician.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PHYSICIAN SERVICES (Continued)

The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.

Ova and Parasites (feces)
Smear for Bacteria, stained
Throat Cultures (Screening)
Red Blood Count
Hemoglobin
White Blood Count
Differential Count
Bleeding Time
Electrolytes
Glucose Tolerance
Skin Tests for:
  Histoplasmosis
  Tuberculosis
  Coccidioidomycosis
  Mumps
  Brucella
Complete Blood Count
Hematocrit
Prothrombin Time
Sedimentation Rate
Glucose (Blood)
Blood Urea Nitrogen (BUN)
Uric Acid
Thyroid Profile
Platelet count
Urine Analysis
Creatinine

Bone Marrow spear and/or cell block; aspiration only
Smear; interpretation only
Aspiration; staining and interpretation
Aspiration and staining only
Bone Marrow needle biopsy
Staining and interpretation
Interpretation only
Fine needle aspiration with or without preparation of smear; superficial tissue
Deep tissue with radiological guidance
Evaluation of fine needle aspirate with or without preparation of smears
Duodenal intubation and aspiration: single specimen
Multiple specimens
Gastric intubation and aspiration: diagnostic
Nasal smears for eospinophils
Sputum, obtaining specimen, aerosol induced technique

PODIATRY SERVICES

Selected services provided by licensed podiatrists are covered by the Kentucky Medical Assistance Program. Routine foot care is covered only for certain medical conditions where such care requires professional supervision.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits are generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Renal service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, must also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

SCREENING SERVICES

Through the screening service element, eligible recipients, age 0-thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Assessment
- Growth and Developmental Assessment
- Screening for Urinary Problems
- Screening for Hearing and Vision Problems
- Tuberculin Skin Test
- Dental Screening
- Screening for Veneral Disease, As Indicated
- Assessment and/or Updating of Immunizations

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

TRANSPORTATION SERVICES

Medicaid may cover transportation to and from Title XIX-covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered is preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services. Travel to pharmacies is not covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists are covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs are covered for persons under age 21.

SPECIAL PROGRAMS

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only are covered under KenPAC. The recipient may choose the physician or clinic. It is especially important for the KenPAC recipient to present his/her Medical Assistance Identification Card each time a service is received.

AIS/MR: The Alternative Intermediate Services/Mental Retardation (AIS/MR) home- and community-based services project provides coverage for an array of community based services that is an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). Community mental health centers arrange for and provide these services.

HCB: A home- and community-based services project provides Medicaid coverage for a broad array of home- and community-based services for elderly and disabled recipients. These services are available to recipients who would otherwise require the services in a skilled nursing facility (SNF) or intermediate care facility (ICF). The services were statewide July 1, 1987. These services are arranged for and provided by home health agencies.

KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES

HOSPICE:

Medicaid benefits include reimbursement for hospice care for Medicaid clients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance are also provided to the patient and his/her family in adjustment to the patient's illness and death. A Medicaid client who elects to receive hospice care waives all rights to certain Medicaid services which are included in the hospice care scope of benefits.

TARGETED CASE MANAGEMENT SERVICES:

Comprehensive case management services are provided to handicapped or impaired Medicaid-eligible children under age 21 who also meet the eligibility criteria of the Commission for Handicapped Children, the State's Title V Crippled Children's Agency. Recipients of all ages who have hemophilia may also qualify.